Illinois Department of Public Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	(X2) MULTIPLE CONSTRUCTION (X: A. BUILDING:		X3) DATE SURVEY COMPLETED	
		IL6003206	B. WING		06/29/2016		
	PROVIDER OR SUPPLIER	1240 NO	RTH MARKE	STATE, ZIP CODE ET STREET			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETE DATE	
S 000	Initial Comments		S 000				
	Annual Licensure a	nd Certification Survey					
S9999	Final Observations		S9999				
	STATEMENT OF L	ICENSURE VIOLATIONS:					
	300.2010a)1) 300.330						
	experience, shall be and nutrition service shall be on duty a n week.	on, qualified by training and e responsible for the total food es of the facility. This person ninimum of 40 hours each					
	300.330 Definitions a person who is a dietetic technician of program, correspond by the American Diegraduate, prior to Juapproved course the of classroom instruction supervision and has supervisor in a heal included consultation successfully completed Association approved or is certified as a difference in food signal management in a management in	: Dietetic Service Supervisor - ietitian; or is a graduate of a or dietetic assistant training iding or classroom, approved etetic Association; or is a or ally 1, 1990, of a Department at provided 90 or more hours etion in food service is had experience as a or at care institution which or from a dietitian; or has eted a Dietary Manager's ed dietary managers course; ietary manager by the Dietary ion; or has training and iservice supervision and illitary service equivalent in ams in the second, third, or		Attachment Statement of Licensure			

Illinois Department of Public Health
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE 07/15/16

PRINTED: 07/26/2016 **FORM APPROVED** Illinois Department of Public Health STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING: \_\_ B. WING IL6003206 06/29/2016 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 1240 NORTH MARKET STREET **PAXTON HEALTHCARE AND REHAB PAXTON. 1L 60957** SUMMARY STATEMENT OF DEFICIENCIES (X4) ID PROVIDER'S PLAN OF CORRECTION ID. (X5)(EACH DEFICIENCY MUST BE PRECEDED BY FULL PRÉFIX **PREFIX** (EACH CORRECTIVE ACTION SHOULD BE COMPLETE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE DATE TAG DEFICIENCY) S9999 Continued From page 1 S9999 These requirements are not met as evidenced by the following: Based on interview and record review, the facility failed to have a qualified Dietetic Services Supervisor who has completed the required training and works 40 hours per week in the dietary department. This failure has the potential to effect all 59 residents. Findings include: E4, Dietary Manager stated on 6-26-16 at 10:15 A.M. that E4 became the Dietary Manager in April 2016. E4 stated she is enrolled in the University of Florida correspondence Dietary Manager course. E4 stated she has completed 23 of the 26 lessons. E4 stated that the 23 lessons have been reviewed and graded. E4 stated that she has three lessons to complete and take the finial examination E4's personnel file documents E4 began as Dietary Manager on 4-21-15. E1, Administrator verified on 6-29-16 at 10:45 A.M. that E4 began as Dietary Manager on 4-21-15. According to the facility's "Resident Census and Conditions of Residents" signed 6-26-16, 59 residents reside at the facility.

Illinois Department of Public Health

300.3260c)

300.3260c) Resident Funds

(AW)

The facility may accept funds from a resident for safekeeping and managing, if it receives written

(X3) DATE SURVEY

Illinois Department of Public Health

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA

AND PLAN OF CORRECTION		IDENTIFICATION NUMBER:	A. BUILDING:		COMPLETED	
		IL6003206	B. WING		06/2	9/2016
NAME OF PROVIDER OR SUPPLIER  STREET ADDRESS, CITY, STATE, ZIP CODE  1240 NORTH MARKET STREET  PAXTON, IL 60957						
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPRIES OF THE	/E ACTION SHOULD BE COMPLET D TO THE APPROPRIATE DATE	
S9999	authorization from, resident or the resident's represent immediate family metall be attested to pecuniary interest in and who is connect personal or the administration of the following:  Based on record refailed to obtain a with the following:  Based on record refailed to obtain a with facility, for residents (R1, R3, R19, and R20) of 18 supplemental residents (R26, R28, R29, R30, R40, R43, R44, R46, R43, R44, R46, R43) which the The findings include On 6-28-16 at 10:48 Manager, E17 providated 6-28-16 of all Trust Fund account "Trial Balance" reporting are managed residents who curreresidents who were Resident Trust Fund provided for the residents Thirty-five of 64 residents, R6, R7, R15, R	in order of priority, the dent's guardian, if any, or the tative, if any, or the resident's ember any, such authorization by a witness who has no in the facility or its operations ed in any way to facility ninistrator in any manner on 2-201(2) of the Act) as not met as evidenced by view and interview, the facility tness who has no interest in ent trust fund written of 64 residents (ten R5, R6, R7, R15, R17, R18, 5 sampled residents and 25 ents{R2, R10, R11, R23, R24, D, R31, R32, R33, R37, R38, D, R47, R49, R50, R51, R52, facility managed trust funds.	S9999			

(X2) MULTIPLE CONSTRUCTION

Illinois Department of Public Health

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
		A. BUILDING:			
IL6003206		B, WING		06/29/2016	
NAME OF PROVIDER OR SUPPL	ER STREET AU	DORESS, CITY, S	TATE, ZIP CODE		
PAXTON HEALTHCARE AI	ID REHAB	RTH MARKET , IL 60957	STREET		
PREFIX (EACH DEFICIE	NCY MUST BE PRECEDED BY FULL	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE COMPLETE	
residents{R2, R R29, R30, R31, R44, R46, R47, trust fund autho someone who h facility or the ad Assistant Company information without the proposition of the include, at a mirror of this Section.  c) Prior to employ that requires a Scontact the Illing Regulation to veractive. A copy of individual's person of this prior to hiring. These requirem by:  Based on intervifailed to follow the some of the prior to the some of the prior to hiring.	HEALTHCARE AND REHAB  SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  Continued From page 3  residents{R2, R10, R11, R23, R24, R26, R28, R29, R30, R31, R32, R33, R37, R38, R40, R43, R44, R46, R47, R49, R50, R51, R52, and R53) trust fund authorizations were not witnessed by someone who has no pecuniary interest in the facility or the administrator. On 6/29/16 E23, Assistant Comptroller was asked if the facility had any information related to the authorizations without the proper witness and E23 said E23 did not.  (B)  Section 300.650 Personnel Policies a) Each facility shall develop and maintain written personnel policies that are followed in the operation of the facility. These policies shall include, at a minimum, each of the requirements of this Section. c) Prior to employing any individual in a position that requires a State license, the facility shall contact the Illinois Department of Professional Regulation to verify that the individual's license is active. A copy of the license shall be placed in the individual's personnel file. d) The facility shall check the status of all applicants with the Health Care Worker Registry prior to hiring. These requirements were not met as evidenced				

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		IL6003206	B. WING		ner	00/2046	
NAME OF			- 60	TATE TO CODE	06/2	29/2016	
	_	1240 NOE	RTH MARKET	TATE, ZIP CODE			
PAXION	I HEALTHCARE AND	REHAB PAXTON,					
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	JLD BE	(X5) COMPLETE DATE	
\$9999	Continued From pa	ge 4	S9999				
	who reside at the fa	acility.					
	Findings Include:						
	7/23/2015 document knowingly employ a resident abuse, new property. The facility any direct care staff crimes listed in the Background Check the provision of the listed on the Illinois Prior to new employ this facility will: .Che Worker Registry on prior reports of abu	Prevention Policy dated nts, "The facility will not any individual convicted of glect, or misappropriation of y will not knowingly employ f convicted of any of the Illinois Healthcare Worker Act (unless waivered under Act), or with findings of abuse Healthcare Worker Registry. Yee starting a work schedule, eck the Illinois Healthcare any individual being hired for se, previous fingerprint check to offender website links on the					
	Office Manager pro Current CNA's (Cer	:00am, E17 (BOM) Business vided an undated list of tified Nursing Assistant) and thin the last four months es of hire.					
	Registry checks and	pm, Healthcare Worker d personnel files were and E1 Administrator and the med by E17:					
	Healthcare Worker 3-9-15. E12 CNA was hired Healthcare Worker until 1-12-16. E11 Dietary Aide was	on 12-21-15, and the Registry was checked on on 12-27-15, and the Registry was not checked as hired on 2-16-16, and no Registry check was provided.					

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IL6003206		IL6003206	B. WING		06/29/2016	
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY,	STATE, ZIP CODE		
PAXTON	HEALTHCARE AND	REHAR	RTH MARKE	T STREET		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	.D BE	(X5) COMPLETE DATE
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Illinois Department of Public Health